Leicestershire County Care Limited

Curtis Weston House

Inspection report

Aylestone Lane
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Curtis Weston House is a residential care home registered to provide personal care and accommodation for up to 44 younger and older adults. People using the service had a physical disability, sensory impairment, dementia, mental health needs and a learning disability or autistic spectrum disorder. At the time of our inspection there were 34 people using the service.

Accommodation is split across two floors accessed by a lift. Communal areas include lounges, bathrooms and toilets.

People's experience of using this service and what we found
Concerns related to protecting people from abuse had not been resolved since the last inspection. There was ineffective management and intervention. Risk assessments did not provide sufficient information and guidance to enable staff to respond consistently when supporting people with distressed behaviours.

Care plans had been rewritten and reviewed since the last inspection but were not person centred. Conflicting information was reported in some records which meant people may not be supported in the most appropriate way. Staff recording was, at times, inaccurate and therefore an accurate picture of support could not always be determined.

Analysis of incidents and accidents were not always effective. Timely action was not consistently taken to identify root cause and measures that could reduce the risk of further incidents of harm for people. People were not always supported to achieve positive outcomes from their care.

Governance remained an on-going concern following on from the last inspection. Audits, although completed, were not always effective in accurately capturing information or driving improvements. Although we found some improvements since our last inspection, these were not yet embedded into working practices to demonstrate they could be sustained.

The provider had appointed a new care manager who intended to apply for registration with the Commission. They had begun to make improvements within the service and staff and people spoke about the positive impact they had made in a short space of time.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Inadequate (supplementary report published 16 April 2020) with a number of breaches of the regulations identified. As a result the service was placed in special measures. We imposed conditions on the provider's registration in March 2020 that they must ensure a) must not admit any new service user without the prior written agreement of the Commission, b) must ensure all care plans

and risk assessments for service users are updated and disseminated to staff, c) must ensure all staff who support service users with nursing or personal care have received training in safe breakaway, sexuality and relationships, positive behaviour support and safeguarding adults and d) must ensure if children from a nursery visit that all care staff involved have received safeguarding children training and appropriate risk assessments are in place. The provider completed an action plan after the last inspection to show us how they would meet these conditions. A monthly report was sent to the Commission detailing progress. At this inspection not enough improvement had been made or sustained by the provider, therefore the service was still in breach of regulations. The service retains an Inadequate rating.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Why we inspected
This was a responsive inspection based on the previous rating and concerns we had received about the service. We received concerns in relation to people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has not changed from inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Curtis Weston House on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to Regulation 12 (safe care and treatment). Regulation 13 (safeguarding service users from abuse and improper treatment) and Regulation 17 (good governance). Existing enforcement measures will remain in place to support the provider to make the required improvements and demonstrate these can be sustained.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. In addition, we will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Curtis Weston House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Curtis Weston House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A manager had been appointed and was in post. They oversaw the day to day running of the service and intended to apply for registration with the Care Quality Commission. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was sending the Commission monthly updates on the action plan that had been created following the last inspection. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who use the service about their experience of the care provided. We also spoke

with four relatives by telephone and received feedback from three relatives after the inspection visit. We spoke with 13 members of staff including the area manager, the care manager, seven care staff, two housekeepers, the chef and the maintenance person. We observed care and support provided in communal areas and during the lunchtime meal.

We reviewed a range of records. This included six people's care plans and records. We also reviewed a sample of medicines records. A variety of records relating to the management of the service including quality assurance surveys and governance audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found around people's care.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had not ensured that all the relevant information was in place to protect people from harm and that potential risks to people had been identified. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment and Regulation 13 safeguarding service users from abuse and improper treatment. Conditions were placed on the provider in March 2020 to ensure all care plans and risk assessments for service users are updated and disseminated to staff, and all staff who support people with personal care have received training in safe breakaway, sexuality and relationships, positive behaviour support and safeguarding adults.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 and regulation 13. Whilst the provider had made some changes to risk management, insufficient changes had been made specifically around the management and support of distressed behaviours.

● Information in care plans had been updated but did not always reflect people's current needs. Risk assessments did not provide sufficient information and guidance to enable staff to respond consistency when supporting people with distressed behaviours.
● One person had experienced an increase in the intensity and frequency of their distressed behaviours. These incidents had, on occasions resulted in harm to other people and staff. The person's risk assessment did not provide sufficient guidance and information to support staff to respond effectively, particularly when the person's behaviour escalated. Four staff were able to describe distraction techniques, though two staff felt these were not effective when the person was in crisis. One member of staff told us they were not confident to respond to distressed behaviours as they had not received the training they needed to understand and manage this. Several staff members felt the person presented risks that they struggled to mitigate on a daily basis. Incidents involving the person had been recorded and external agencies notified. However, records failed to show any post-incident analysis or de-brief for staff to identify new risks and lessons learnt. Staff confirmed they did not receive a post-incident de-brief.
● We raised concerns with the care manager and area manager regarding immediate risks for the person and others due to the intensity of their distressed behaviours. They assured us they would take immediate action following our inspection visit to ensure the person and others were safe from abuse and harm.
● We observed one person becoming increasingly distressed and restless during our inspection visit. Although the person received periodic intervention from staff, there was no planned intervention or distraction to enable the person to manage their anxiety. The person had no opportunity to engage in a meaningful activity to occupy them. This resulted in the person's distress and anxiety increasing to the point

they attempted to leave the premises.
● Care plans were not always accurate or reflective of people's specific needs or risks. For example, one person had limited mobility and was rigid in their movements. This presented a challenge in terms of supporting the person to transfer with equipment. Their care plan including conflicting information around their mobility, with some areas instructing staff to support the person to be mobile if they were able to, whilst other areas advised staff the person was no longer independently mobile and required equipment to transfer them. We found the person half in and half out of bed. A crash mat and movement sensor were in place to support them if they fell out of bed and the bed was at its lowest position. When we alerted staff to this, staff informed us the person regularly got themselves into this position. Their care plan did not include this information and assessed the person as having no history of falls and not at risk of falling. Records showed the person had fallen out of bed the previous month.
● The care manager had reviewed people's Malnutrition Universal Screening Tool (MUST). This is a tool used to determine people's risk of malnutrition. Where people were at risk of poor nutrition, monitoring charts included daily fluid intake targets. Although improvements were found in overall monitoring and recording of people's nutrition, we found gaps in records. For example, we reviewed records for one person over a six day period and found the daily fluid intake to be below the required target for five days. The care manager had identified where improvements were needed in monitoring and recorded and told us they had introduced new systems to ensure prompt action could be taken where people had not had sufficient fluids. This was particularly important as several people had been admitted to hospital with symptoms of retention and dehydration.
● We looked at records of repositioning for people who had been identified as high risk of poor skin integrity. We found overall improvements in these records, although gaps were still evident in recording times of repositioning in line with assessed needs. We spoke with one person who received support to manage a pressure wound. They told us, "The [district] nurses come in to change my dressing and the staff keep an eye on the wound and make sure the dressing is clean. It is healing."
● Staff felt comfortable to raise concerns and understood whistleblowing procedures to escalate concerns outside of the service if needed. Incidents were reported to external agencies, such as local authority commissioners so they had the opportunity to ensure appropriate action had been taken to keep people safe.

Learning lessons when things go wrong
● The service maintained records of accidents and incidents. Records showed there was rarely an analysis concluded to determine the cause of the incident. Some records showed action was taken to prevent a similar occurrence, for example referral to falls team or consultation with GP. However, incidents of distressed behaviours did not include any formal de-brief for staff or review to reduce risks for the person or others. There was no evidence action had been take to achieve positive outcomes for people.
● Staff discussed incidents and accidents verbally during shift handover.

Using medicines safely
● We observed part of a medicine round and the member of staff completing this ensured they spoke with people, explaining what the medicine was for before administering. Medicines were appropriately signed as given within the medicine administration record (MARs). However, when we checked records we found several MARS charts for the week had gaps in signatures which could indicate staff had forgotten to sign or had not administered the medication as prescribed.
● Stock medicines were correctly stored. MARs contained people's details including a photograph ensuring the correct person was administered the medicines.
● The area manager had undertaken an audit on medicines and found several areas where improvements were required. Staff had begun to make some improvements, but this was not supported by an action plan

to provide clarity in terms of roles, responsibilities and timescales.

Preventing and controlling infection

● Housekeeping staff were responsible for maintaining the cleanliness of the home. There was a cleaning schedule in place and records showed this was followed throughout the day.

● Areas of the premises posed an infection control risk, such as flooring in bathrooms and toilets. This had been identified at our previous inspection and the provider told us they had made arrangements for flooring to be replaced imminently when it was safe for contractors to be on site. Several chairs had been replaced in communal areas to support effective cleaning of key areas such as arms and seats.

● Staff had access to PPE, such as face masks, gloves and aprons, and we saw this was in use during our inspection visit.

● People were supported to isolate if they showed symptoms associated with COVID-19 or had recently been discharged from hospital. However, we saw one person who we were told was self-isolating, in a communal area. They told us this was because they were unable to operate the television in their room. We raised this with staff to ensure areas were thoroughly cleaned and the person had access to the items and stimulation they needed to remain in their room.

Staffing and recruitment

● Planned staffing levels were achieved and people were supported by a consistent staff team that knew them well.

● People told us there were enough staff to meet their basic care needs. However, we observed that staff had very little time to spend with people and some people were bored and under-stimulated.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found people had been harmed or were at risk of harm as systems and processes were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection, therefore the provider remained in breach of regulation 17. Whilst audits were completed these did not always highlight issues or concerns we found during the inspection. Systems and processes were not embedded in working practices to demonstrate improvements could be sustained to support positive outcomes for people.

- The manager and provider had begun to implement systems and processes to maintain more effective oversight of the service. However, these were in early infancy and demonstrated where improvements were required in response to external concerns. There was a lack of systematic response to identify resources and support needed to achieve a pro-active approach in making improvements.
- Audits and checks were taking place but these were not always effective in driving improvements. For example, care plans had been reviewed but did not always reflect people's current needs or provide guidance to support personalised care. Audits of falls and incidents did not always lead to effective reviews or measures implemented to reduce risk of further occurrences. People with distressed behaviours were not consistently supported or engaged in meaningful interventions.
- There was no registered manager in post. The care manager intended to apply for registration with the Commission and was supported by an area manager. The care manager had worked diligently to identify where improvements were needed and was involving staff in making the necessary changes.
- Staff were complimentary about the impact the care manager had made in a short space of time and described how they felt the service had improved. Comments included, "Things have improved and the new manager is really supportive, works on the floor if needed and always checking if we are okay. Covid has been a difficult time and we have lost people which has been very stressful. There is better communication now," and "The manager is open. I was told about the current rating when i started and why they had it. The new manager is very good, they have made a difference already. They are supportive and we can go into office and seek advice when we need to."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people
● Staff generally reported a positive culture of the home, specifically since the new care manager had been appointed.
● The care manager was available and visible throughout the service, completing walk arounds and providing support and guidance for staff. They were supported by an area manager who was aware and told us they were committed to making the improvements required.
● Whilst the care manager and staff team tried to ensure good outcomes for people, our inspection visit found these were not consistently achieved. Care plans and records were not always personalised to reflect people's specific support needs and wishes.
● People were not supported to engage in meaningful interaction and experiences.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The care manager made notifications to relevant agencies when something went wrong in the service. There were improvements in notifications of significant incidents overall.
● Although correspondence when a specific incident occurred was transparent, outcomes of the investigations were not always clearly detailed. In most cases, the person or their representative had been given the opportunity to liaise with the care manager about the incident.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The care manager had spent time in the service and had begun to collate people, staff and relatives views to improve the service. This included staff spending time as a person using the service, to gain experience of what life is like. Initial feedback highlighted the loneliness, isolation and boredom staff felt during this time.
● The care manager provided staff with supervision which promoted team working and individual accountability. Staff we spoke with told us they found this positive. Handovers were detailed and provided important information between each shift.
● The care manager advised making the changes to bring about improvements was a long process. A number of improvements and issues were to be actioned. An action plan had been developed specifically focusing on these, including how and when each action would be met, with a timescale.